

- (3) Iron ore;
- (4) Other mine products;
- (5) Coal;
- (6) Coke;
- (7) Petroleum products;
- (8) Chemicals;
- (9) Stone;
- (10) Salt;
- (11) Other bulk cargo;
- (12) Iron and steel;
- (13) Other general cargo;
- (14) Containers.

(d) Cargoes having been the subject of a new downbound or new upbound business refund shall be excluded from the statistics used for the calculation of volume discounts.

(e) Notwithstanding anything in this Tariff (33 CFR part 402), a carrier shall not obtain, at the end of a navigation season, both a volume discount and a new downbound or upbound business refund with respect to the same shipment, but a carrier shall obtain the greater of the said discount or refund.

Issued at Washington, DC on January 13, 1992.

The Saint Lawrence Seaway Development Corporation.

Stanford E. Parris,  
Administrator.

[FR Doc. 92-1330 Filed 1-21-92; 8:45 am]

BILLING CODE 4910-61-M

## ENVIRONMENTAL PROTECTION AGENCY

### 40 CFR Part 52

[IA5-1-5380; FRL-4039-5]

### Approval and Promulgation of Implementation Plans; State of Iowa

AGENCY: Environmental Protection Agency.

ACTION: Final rule.

**SUMMARY:** The Iowa Department of Natural Resources (IDNR) has submitted revisions to its open burning rule, 23.2. The revisions approve exemptions for the burning of trees and agricultural structures. EPA is taking final action to approve these revisions in the Iowa State Implementation Plan (SIP).

**DATES:** This action will be effective March 23, 1992 unless notice is received within 30 days of publication that adverse or critical comments will be submitted. If the effective date is delayed, timely notice will be published in the Federal Register.

**ADDRESSES:** Copies of the state submittal for this action are available for public inspection during normal business hours at: The Environmental Protection Agency, Region VII, Air

Branch, 726 Minnesota Avenue, Kansas City, Kansas 66101; Public Information Reference Unit, Environmental Protection Agency, 401 M Street, SW., Washington, DC 20460; and Environmental Protection Division, Iowa Department of Natural Resources, Henry A. Wallace State Office Building, 900 East Grand, Des Moines, Iowa 50319.

**FOR FURTHER INFORMATION CONTACT:** Wayne A. Kaiser at (913) 551-7603 (FTS 276-7603).

**SUPPLEMENTARY INFORMATION:** On October 3, 1991, the Iowa Department of Natural Resources submitted a revision to its SIP which includes revisions to Iowa Pollution Control Rule 23.2—Open burning, Chapter 23—Emission Standards For Contaminants. This revision was effective in the state on September 12, 1990.

The minor rule revisions consisted of three changes to rule 23.2. First, 23.2(3) Exemptions, paragraph b—diseased trees, was replaced in its entirety with language that exempts from the open burning prohibition trees and tree trimmings not originating on the premises, provided the burning is controlled and operated by a local governmental entity. Old paragraph 23.2(3)b exempted only diseased trees. Diseased trees would still be exempt from the open burning prohibition under the revised rule. The exemption would not be permitted in major urban areas of the state.

Second, rule 23.2(3) is revised by adding a new paragraph "i" to exempt the open burning of agricultural structures in rural areas. The rule states this exemption is applicable only if, among other things, the agricultural structures are outside of cities or towns, have had all chemicals and asphalt shingles removed, and permission is obtained from the local fire chief in advance of burning. Also, rubber tires shall not be used to ignite the structures. A definition of "agricultural structures" is provided.

Third, rule 23.2(4)—Unavailability of exemptions in certain areas, was revised to be consistent with revised subrule 23.2(3)b pertaining to trees or tree trimmings, rather than diseased trees.

EPA believes that these rule revisions will not cause or contribute to any violation of the National Ambient Air Quality Standard, especially with respect to particulate matter. There are no nonattainment areas for particulate matter in Iowa. Furthermore, the open burning is restricted to rural areas where ambient particulate levels are well within the standard.

The state provided proper public notice of the proposed revisions and

made available the opportunity for public comment and hearing. The revised rule was adopted by the Iowa Environmental Protection Commission and became effective on September 12, 1990.

EPA is publishing this action without prior proposal because the Agency views this as a noncontroversial amendment and anticipates no adverse comments. This action will be effective March 23, 1992 unless, within 30 days of its publication, notice is received that adverse or critical comments will be submitted.

If such notice is received, this action will be withdrawn before the effective date by publishing two subsequent notices. One notice will withdraw the final action and another will begin a new rulemaking by announcing a proposal of the action and establishing a comment period. If no such comments are received, the public is advised that this action will be effective March 23, 1992.

### EPA Action

EPA is taking final action to approve a revision to Iowa rule 23.2 pertaining to open burning.

Nothing in this action should be construed as permitting or allowing or establishing a precedent for any future request for revision to any SIP. Each request for revision to the SIP shall be considered separately in light of specific technical, economic, and environmental factors and in relation to relevant statutory and regulatory requirements.

Under 5 U.S.C. 605(b), EPA certifies that this SIP revision will not have a significant economic impact on a substantial number of small entities (see 46 FR 8709).

This action has been classified as a Table 3 action by the Regional Administrator under the procedures published in the Federal Register on January 19, 1989 (54 FR 2214-2225). On January 6, 1989, the Office of Management and Budget waived Tables 2 and 3 SIP revisions (54 FR 2222) from the requirements of Section 3 of Executive Order 12291.

Under section 307(b)(1) of the Act, petitions for judicial review of this action must be filed in the U.S. Court of Appeals for the appropriate circuit by March 23, 1992. Filing a petition for reconsideration by the Administrator of this final rule does not affect the finality of this rule for the purposes of judicial review, nor does it extend the time within which a petition for judicial review may be filed, and shall not postpone the effectiveness of such rule or action. This action may not be

challenged later in proceedings to enforce its requirements. (See Section 307(b)(2).)

#### List of Subjects in 40 CFR Part 52

Air pollution control, Incorporation by reference, Intergovernmental relations, Particulate matter.

November 25, 1991.

Morris Kay,

Regional Administrator.

#### PART 52—[AMENDED]

40 CFR part 52 is amended as follows:

1. The authority citation for part 52 continues to read as follows:

Authority: 42 U.S.C. 7401-7642.

#### Subpart Q—Iowa

2. Section 52.820 is amended by adding paragraph (c)(56) to read as follows:

##### § 52.820 Identification of plan.

(c) \* \* \*

(56) Revised Chapter 23, rule 23.2, submitted on October 3, 1991, incorporates changes to the open burning rule.

(i) Incorporation by reference.  
(A) Amendment to Chapter 23, "Emission Standards for Contaminants," Iowa Administrative Code, subrule 23.2, adopted by the Environmental Protection Commission, effective September 12, 1990.

(ii) Additional information.  
(A) Letter from Allan Stokes, IDNR, to William Spratlin, dated October 3, 1991.

[FR Doc. 92-1413 Filed 1-21-92; 8:45 am]

BILLING CODE 6560-50-M

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

##### Public Health Service

#### 42 CFR Part 5

RIN 0905-AC68

#### Criteria for Designation of Mental Health Professional Shortage Areas

AGENCY: Public Health Service, HHS.  
ACTION: Final rule.

**SUMMARY:** This final rule amends the existing regulations governing the criteria for designation of health manpower shortage areas, or HMSAs (now health professional shortage areas, or HPSAs; name changed by Public Law 101-597, the National Health Service Corps Revitalization Amendments of 1990) under section 332 of the Public

Health Service Act. Specifically, this amendment revises the existing criteria for designation of HMSAs having shortages of psychiatric manpower, transforming them into criteria for designation of HPSAs having shortages of mental health professionals, to take into account not only psychiatrists but also mental health service providers other than psychiatrists. The intended effect of this amendment is to more accurately assess the supply of mental health service providers when making shortage area determinations. This notice also summarizes the comments received by the Department on the Notice of Proposed Rulemaking published on August 8, 1989, which set forth the proposed methodology for making this and other changes to the HMSA criteria. It also formally changes "HMSA" to "HPSA" throughout the regulation, to conform with Public Law 101-597.

**EFFECTIVE DATE:** This rule will be effective upon publication.

**FOR FURTHER INFORMATION CONTACT:** Richard C. Lee, Director, Office of Shortage Designation, Bureau of Health Care Delivery and Assistance, Health Resources and Service Administration, Parklawn Building Room 4-101, 5600 Fishers Lane, Rockville, Maryland 20857 (telephone: 301-443-6932).

**SUPPLEMENTARY INFORMATION:** Section 332 of the Public Health Service Act, as amended by Public Law 101-597, requires the Secretary to establish, by regulation, criteria for the designation of Health Professional Shortage Areas (HPSAs). The regulations setting forth these criteria are codified at 42 CFR part 5. On August 8, 1989, the Department published a Notice of Proposed Rulemaking (NPRM) which proposed certain changes to the then-HMSA criteria, and requested public comments. The NPRM proposed to revise appendix C of the existing regulations, until now entitled "Criteria for Designation of Areas having Shortages of Psychiatric Manpower," to take into account clinical (or "health-service-provider") psychologists, clinical social workers and psychiatric nurse specialists, as well as psychiatrists, in the designation of mental health manpower shortage areas. It also proposed a new minimum size-of-shortage criterion for primary care, dental and mental health HMSAs.

Seventy letters were received commenting on various aspects of the proposed changes to the HMSA criteria. The Secretary would like to thank the respondents for the quality and thoroughness of their comments. As a result of these comments, the Department has reconsidered its

position on a number of issues raised and made modifications accordingly. The comments and the Department's responses are discussed below, arranged according to the subjects raised.

#### Minimum Size-of-Shortage Criterion

Fifty of the seventy letters received dealt with the one proposed change that applied not only to the psychiatric or mental health HMSA criteria, but also to the primary medical care and dental HMSA criteria, i.e. the imposition of a new minimum size-of-shortage criterion. Under the proposed change, a computed need for at least 1.0 additional full-time-equivalent (FTE) practitioner (to lower the population-to-practitioner ratio to the minimum level already required by the criteria for designation) would have to exist within the area or population under consideration for HMSA designation, unless the area or population was already served by less than 0.2 FTE practitioners.

As many of the commentors point out, this change would eliminate about 1/3 of all primary medical care HMSA designations. The NPRM stated that most of the affected primary care and dental HMSAs would have had very low priorities for placement and, therefore, were already unlikely to receive National Health Service Corps (NHSC) personnel. However, as a large number of the commentors point out, many Federal and State programs other than the NHSC are dependent on HMSA designations. In the areas that would lose their designations, both existing NHSC sites and these other programs would be in jeopardy. According to the House and Senate Rural Health Caucus and other commentors, this change would have a severe negative impact on rural and frontier areas. Other commentors stated that this change would also artificially reduce the number of HMSAs, implying a decline in the need for health professionals when problems with recruitment and retention are, in fact, a major current concern for community health centers in HMSAs.

Some commentors suggested that the proposed change was an effort to solve a placement problem—too many areas requesting the few available NHSC practitioners—with a change to the shortage criteria that would reduce the number of HMSAs. One commentor expressed concern that population group designations would be particularly jeopardized by the proposed size-of-shortage change because they have a smaller population base.

The Department recognizes and appreciates the concerns raised about

the proposed minimum size-of-shortage criterion, particularly that the proposed change could negatively affect areas' eligibility for programs other than the NHSC. Therefore, the Department is withdrawing this particular proposed amendment to the HNSA criteria. However, we expect that the size of the shortage will continue to be an important NHSC placement factor.

#### Proposed Change From Psychiatric to Mental Health Professional Shortage Criteria

At least five commentors stated simply that they supported the change from psychiatric shortage criteria to mental health professional shortage criteria, including clinical psychologists, clinical social workers, and psychiatric nurse specialists. Others expressed support for the general concept and questioned some of the specifics; their comments are dealt with below. Several others expressed support for this change but concentrated their comments on their opposition to the proposed size-of-shortage criterion.

Three commentors, including the American Psychiatric Association (APA), stated the opinion that mental health professionals other than psychiatrists should not be included due to their lack of skills in biological/medical fields. According to these commentors, such professionals can do psychotherapy but cannot recognize physical/medical components of mental health problems. The Department rejects the contention that only psychiatrists should be included as mental health professionals. The proposed methodology gives extra weight to psychiatrists because of their unique position as physicians.

The APA objected to a statement in the NPRM's preamble suggesting APA support of the proposed revisions, and stated that the APA strongly opposes transforming the existing psychiatric shortage criteria into criteria for mental health professional shortages, including non-physician practitioners. However, an earlier Health Resources and Services Administration study of how such a revision might be made was, in fact, coordinated both with the APA and with associations representing the other mental health professional groups. At that time, there seemed to be a consensus that there is overlap in roles between the various types of mental health professionals and that, if the overlap could be properly quantified, all the associations involved could support the use of mental health professional shortage criteria. Unfortunately, a proposed survey which was developed to exactly quantify this overlap in

functions did not achieve clearance and therefore was not carried out. While the methodology used in the NPRM may be less satisfactory, the Department believes it represents a clear improvement over the previous psychiatrist-only approach, and, therefore, will retain it as proposed.

According to some commentors, the term "counseling" should have been included instead of or as well as "psychotherapy" in the description of the overlap in functions of the core mental health service providers. We agree. However, this would not affect the regulations themselves.

#### Types of Mental Health Professionals Included

One commentor noted that master's level psychologists were omitted from the definition of the "core" mental health service professionals, although social workers and nurses trained at the master's level were included. This commentor stated that it is difficult to recruit doctorate-level psychologists to underserved rural areas; that many of the psychologists providing services in the public mental health sector hold only master's degrees; and suggested that it is reasonable to believe that master's-level psychologists can function at the same level as nurses or social workers trained at the master's level.

In response, the Department wishes to point out that the approach taken in the development of these criteria was to include those numbers of each core mental health service professional group that had received the highest level of training available in that discipline. In this way, the professionals included are those that are clearly fully-trained according to their colleagues, just as psychiatrists are only considered fully trained if they have completed medical school and residency in psychiatry. While we recognize that this leads to inclusion of holders of master's degrees in two of the disciplines while only holders of doctorates are accepted in the other two, we nevertheless believe that this approach is basically sound. Since only one comment to the contrary was received, we conclude that most psychologists reading the notice were in agreement with the restriction to holders of doctorates, and we do not plan to alter this approach.

The American Association for Marriage and Family Therapy (AAMFT) commented that marriage and family therapists should be included in the definition of core mental health professionals in the new criteria. They pointed out that 20 States license or

certify marriage and family therapists; 41 graduate degree and post-degree training programs in this field have been accredited by the Commission on Accreditation for Marriage and Family Therapy Education; 600 additional training programs offer coursework in this field; and more than 16,000 qualified practitioners are members of the AAMFT. In addition, this discipline has already been recognized in relevant legislation; it was added in 1988 to the other four disciplines eligible for mental health traineeships under Section 303 of the Public Health Service Act. (Recipients of such traineeships are obligated to serve in HPSAs, in public inpatient mental institutions, or in other areas or entities designated by the Secretary under section 303.)

The Department agrees with this suggestion. The regulation has been revised to include this discipline. The definition of marriage and family therapists for this purpose includes those individuals (normally with a master's or doctoral degree in marital and family therapy and at least two years of supervised clinical experience) who are practicing marital and family therapy and are licensed or certified to do so by the State of practice; or, where licensure or certification is not required, are eligible for clinical membership in the AAMFT. (The use of "master's or doctoral" here is because some accredited programs lead only to the master's degree, while others lead only to the doctoral degree; our intent is that the programs covered be accredited and lead to at least a master's degree, analogous to the situation in social work.)

One commentor suggested that we also include registered occupational therapists, licensed physical therapists, vocational therapists, registered dietitians and registered pharmacists as part of the interdisciplinary team of professionals considered in the mental health shortage criteria, although no suggestion was included as to how or with what weight to include them. The Department recognizes that these professionals provide important contributions to the care given to persons suffering from mental health disorders, but the services they provide are not interchangeable with those provided by the core disciplines already identified, and shortages of these professionals are not correlated with shortages of psychiatrists, psychologists, etc. Therefore, this change is not being made.

### Methodology Used in Combining Different Mental Health Professional Types

One commentator objected to the use of a population-to-core professional ratio involving the simple addition of the "core" types of mental health professionals. According to the commenter, this approach assumes that the core types are all equal, even though only psychiatrists have hospital admitting privileges and can prescribe medication. In response, the Department points out that although the core types are treated equally in the particular ratio question, the proposed methodology also uses the ratio of population-to-psychiatrists by themselves, specifically to take into account the medical role which only psychiatrists can exert.

Two commentators suggested that the criteria should treat all mental health professionals equally, resulting in the use of a single ratio, rather than using a mixture of one population-to-core-professional ratio and one population-to-psychiatrist ratio, which treats psychiatrists differently. These commentators pointed out that there is growing collaboration between primary care physicians and non-physician mental health professionals; that there is existing expertise in psychopharmacology and some options for limited prescription privileges among non-physician mental health professionals; and that the overwhelming majority of mental health patients do not require medication. They also stated that, according to CHAMPUS data, all the core mental health professionals treat schizophrenia and affective disorders as well as neurotic and personality disorders and adjustment reaction problems.

Despite the factors cited, the Department recognizes a distinct role for the psychiatrist. Furthermore, the methodology as proposed implicitly allows for a smooth transition from the previous criteria, based primarily on the population-to-psychiatrist ratio, to the new criteria which take into account both that ratio and the population-to-core-professional ratio.

One commentator felt that areas with adequate psychiatric coverage but shortages of clinical social workers or psychiatric nurses would not be identified by the proposed designation process, and that separate shortage designations for each type of mental health professional would be better. In response, the Department points out that the purpose of the criteria is to identify areas with shortages of mental health professionals. Clearly, the particular

type of mental health professional(s) needed in each area will vary according to what types, if any, are already there; the characteristics of the population involved; and the need to have a balanced team of various types of professionals to meet community needs. This degree of specificity will need to be worked out on a site-by-site basis, just as the needs of individual sites identified as primary medical care HPSAs are currently analyzed to determine whether the site requires a family practice physician; a pediatrician, internist, or obstetrician/gynecologist; or a nurse practitioner, nurse midwife, or physician assistant.

### Choice of Ratio Levels in the Mental Health Shortage Criteria

Several commentators pointed out that national average population-to-provider ratios do not necessarily represent adequacy levels; their use presupposes the adequacy of current supply to meet demand if it were equitably distributed. They stated that the rationale for "shortage = 1.5 to 2.0 times national mean" is not clear, and suggested that lower levels of these ratios should instead be used. According to these commentators, previous research has shown that many individuals with mental health problems are not receiving service for a variety of reasons, including inaccurate diagnosis, fear of being labeled, geographic remoteness from available care and insufficient financial resources to pay for treatment. Therefore, they believe the threshold ratios in the criteria should be carefully monitored for accuracy and utility as indicators of shortage, and replaced if evidence of the appropriateness of using smaller ratios is found. They further suggested that research be conducted to obtain better criteria. The Department concurs that research should go forward and that future changes should be considered if a better basis for threshold ratios is developed.

### Data Issues

Two commentators pointed out that the available data on the number of professionals in each of the core disciplines are variable in scope, accuracy, currency and completeness and are not necessarily comparable; this could result in errors in the choice of threshold ratios and in the designation of particular areas. The Department recognizes that this may be a problem, but sees no immediate practical solution, except to urge both the States and the professional associations involved to improve the quality of their

data on these professionals wherever possible.

Three commentators stated that in order to determine accurately the numbers of mental health professionals in these disciplines, expensive surveys would be required, especially in States where not all four types are licensed, certified or registered. Again, the Department recognizes and appreciates that this is likely to be a problem, particularly in States where no existing system is in place to collect data on one or more of the professions involved. States will need to make judgements about whether the expense of setting up such a system will likely yield benefits, not only to ease HPSA designation but also in monitoring these professionals in connection with other programs.

### High Need/Insufficient Capacity Indicators

Several commentators, including four associations of mental health professionals, recommended that the Department not drop age-related indicators of high need. Two associations indicated that, contrary to the statement in the preamble to the NPRM, the Epidemiological Catchment Areas study cited did not include individuals aged 17 or younger, and further stated that no high-quality data exist on the prevalence of mental disorders in children and adolescents. These commentators argued further that high need determinations should not be based on utilization data, since previous research has shown that although children and the elderly are at no lower risk of experiencing mental health problems than the rest of the population, they tend to underutilize mental health services due to problems of inaccurate diagnosis, limited accessibility, and lack of financing.

A third commentator recommended that a large aged population be retained as a high need indicator, since "studies point to a correlation between the availability of mental health services and decreased utilization of unnecessary medical care, particularly among the aging population." A fourth commentator stated that higher rates of suicide occur among the elderly than in any other group, and that high rates of "self-destructive" behavior occur in young adults, specifically males. A fifth commentator recommended that we retain both the youth and elderly indicators because of "the strong evidence provided by empirical research that the psychiatric needs of the elderly are underserved" and "the strong evidence that children/adolescents have 'high need' for psychiatric services due to their

involvement in the use of illegal drugs and the evidence of high co-morbidity between mental disorders and substance abuse disorders."

Based on these comments, the Department will retain the youth and elderly high need indicators.

Some commenters noted that alcoholism and other substance abuse are important indicators of high need and should be included. They felt that the lack of availability of a national alcoholism index should not mean that alcoholism rates will not be considered; alternative measures should be used. The Department concurs and will add an allowance for the use of indicators of high prevalence of alcoholism or substance abuse, where available.

One commenter suggested that other factors such as homelessness, unemployment, natural disasters and HIV-endemic areas should also be considered for high needs. In response, the Department points out that an estimate of the number of homeless persons can be included in geographic area designations, and a homeless population can be separately designated as a population group or combined with the poverty population in a poverty/homeless population group. At this time, the Department does not plan to include any of the other suggested variables as high need factors.

Another commenter suggested that adjustments for high needs also be made for families receiving AFDC or other public income support, as well as for areas with elevated rates of school dropouts, homicide, and suicide. In response, the Department points out that several of these factors correlate with percent of the population below poverty, already used as a high need indicator. We are not prepared to adjust for local levels of school dropouts, homicide, and suicide.

Two commenters raised the question of how poverty is defined for the purposes of HMSA designation and expressed reservations about basing it on Department of Agriculture estimates of cost for a family of four to purchase food. One also commented that the rationale for using poverty "should acknowledge the established relationship between social status and mental disorders." In response, we feel that although any definition of poverty would likely be imperfect, it is important to have a single government-wide standard. The Bureau of the Census, rather than the Department of Health and Human Services, is responsible for annual updates of the official Federal Government statistical poverty thresholds, and application of those thresholds to prepare statistical

estimates of the number of persons and families in poverty. (Contact: Enrique Lamas, Chief, Poverty and Wealth Statistics Branch, U.S. Bureau of the Census.)

Poverty is used in the primary medical care HPSA criteria because it tends to correlate with both lower health status and lack of access to health services; in the mental health HPSA criteria, the same correlation is assumed.

One commenter suggested there should be language in the rule to recognize areas in which a disproportionate number of chronically mentally ill reside. This would be a good suggestion, but for the fact that data on residence locations of the chronically mentally ill is not generally available, except where they are institutionalized. The institutionalized mentally ill are addressed in the existing mental health facilities criteria.

According to one commenter, the importance of language or cultural barriers should be reinforced, as well as the related shortages of professionals sensitive to minority populations and cultures, and the resulting disproportionate representation of minorities in State mental hospitals. In response, the Department notes that the population group HMSA criteria already address language and cultural barriers; the selection criteria for recipients of NHSC scholarships and loan repayments and for hiring in general emphasize minorities; and the NHSC's matching process stresses culturally sensitive placements.

According to one commenter, the criterion for determining insufficient capacity for a facility from number of patient visits per provider, as currently written, appears to allow consideration only of patient visits at the facility rather than counting staff visits outside the facility to serve the patients' needs. In response, the word "patient" is meant to include all patients served by the facility's staff as a service of that facility, whether on or off site. This, of course, would not include patients served by facility staff through private practices, if any.

#### Service Area/Contiguous Area Issues

According to one commenter, the proposed regulations would change the way of measuring distance to contiguous resources, by measuring the distance of the contiguous resources from the closest population center of the area proposed for designation, rather than from its geographic center, in contrast to the approach used in primary care and dental HMSA designation; this could lead inappropriately to dedesignation of some areas.

The wording of the contiguous area criterion as stated in the mental health criteria (appendix C) does appear to be slightly different from that stated in the primary medical care and dental criteria (appendices A and B). However, no functional difference was intended. Where a service area has one major population center, distances/travel times to contiguous resources are to be measured from this center; where the population is fairly evenly distributed, distances/travel times are to be measured from the geographic center; where two population centers of roughly equal size are present, distances may be measured from a point halfway between them. However, where three or more population centers are present, as in the case of many multi-county mental health catchment areas, no simple rule is obviously applicable. Therefore, for these larger areas, we use the practical approach of measuring the distance from each contiguous area's population center to the nearest population center of the service area.

#### Other Issues on Mental Health Shortage Criteria

One commenter suggested that separate mental health shortage criteria be developed for children and adolescents, involving providers such as child psychiatrists, psychologists, speech pathologists, audiologists and therapists.

The Department points out that separate criteria for children and adolescents would logically require that we also do separate criteria for adult males, females of child-bearing age, females not child-bearing age, etc. We would then need to allocate each practitioner's time in patient care to one or more of these age/sex groupings. The age/sex groupings should be nonoverlapping, which would be difficult or impossible (for example: adolescent females fall in two or three categories). The whole system would thus become impossibly complex; we do not plan to proceed in this direction.

#### Other Issues on the Primary Medical Care HMSA Criteria

One commenter suggested that the HMSA criteria were already too stringent, and that the population-to-practitioner ratio required for designation should be reduced, particularly in high need areas such as those with high percentages of elderly. However, there seems to be relative satisfaction with the existing levels on the part of most commenters. At this time, the Department is making no change to the population-to-practitioner

ratios required for primary care and dental HPSA designation.

One commentator suggested that separate criteria for shortages of obstetricians should be developed, since areas which have no overall shortage of primary care physicians can have shortages of obstetricians and resulting elevated rates of infant mortality, low birth weight babies, and inadequate prenatal care. Our response to this is analogous to that for the previous issue regarding separate mental health shortage criteria for children and adolescents. In sum, our approach is that an area or population should be identified as having an overall primary medical care shortage in order to qualify for designation, not just a shortage for a particular age/sex group or a particular type of primary care physician.

One commentator raised the issue that service areas in the west are much larger and the populations that comprise market areas much smaller than in the rest of the country, and suggested that the HMSA regulations regarding rational service areas be modified to recognize these geographic differences. In response, we recognize this problem, particularly in the case of frontier areas. We therefore will allow some flexibility, i.e., use of larger service areas, in designation of frontier or near-frontier areas.

Two commentators suggested that a lower population-to-primary care provider ratio be used in isolated and low-density rural and frontier areas, and pointed out that this need was recognized in the preamble to the 1980 publication of the HMSA criteria but that nothing has been done. The Department has made no decision to reduce the population-to-practitioner ratios required for HPSA designation of frontier areas; however, under section 6213(c) of Public Law 101-239, areas which have not been designated as HPSAs but have been identified under State criteria and designated by State Governors as having shortages for State program purposes can be certified by the Secretary as appropriate for Rural Health Clinic purposes. Frontier areas designated by States using population-to-practitioner ratios less than the HPSA designation threshold could quite possibly achieve such certification.

#### Designation Process Issues

One commentator suggested that the medically underserved area (MUA) and HMSA designation processes be combined. These two designation processes have been kept separate because each is the basic requirement for a particular program, i.e., HMSA designation for NHSC placement and

MUA designation for community health center (CHC) funding. However, primary medical care health manpower shortage is really one type of medical underservice. Regulation changes now being considered for the CHC program would make primary medical care HPSAs automatic MUAs.

#### Publication Process Issues

Two commentators expressed concern that the proposed rules changes were referenced incorrectly in the **Federal Register's** Table of Contents; these commentators felt that the comment period should be extended or the rules change republished. The Department regrets the publication error, but did consider comments received after expiration of the formal comment period deadline.

#### *Regulatory Flexibility Act and Executive Order 12291*

This rule reforms the criteria for designating the geographic areas in which a small fraction of National Health Service Corps enrollees are placed. It thereby establishes one condition for this type of Federal financial assistance to such areas. No standards in this rule go beyond the minimum necessary to achieve this purpose effectively. The benefits of this rule arise from improved measurement of mental health shortage areas, through taking into account not only psychiatrists but also other mental health service providers. This rule imposes no direct costs. As discussed elsewhere in this preamble, a number of alternatives were considered. We selected alternatives which minimize unnecessary complexity, minimize unnecessary change and disruption to the existing system, and recognize the most important and salient needs for mental health services.

Most areas designatable under the previous criteria will also be designatable under the revised criteria, although their degree-of-shortage group may change. When both psychiatrists and other core mental health service professionals are considered, some new mental health HPSAs will be designatable. However, since the number of obligated-service psychiatrists (or other core mental health professionals) available for placement in mental health HPSAs is limited, only a few placements will occur in newly-designated areas.

As a result, this rule meets the general requirements under Executive Order 12291 for maximizing benefits and minimizing costs, and the Secretary has determined that this rule will not impose costs of \$100 million or otherwise meet

the criteria for major rule established in the Executive order. Therefore, a Regulatory Impact Analysis is not required. The Secretary also certifies that this amendment to the regulations does not have a significant economic impact on a substantial number of small entities. Therefore, a Regulatory Flexibility Analysis is not required.

#### *Paperwork Reduction Act of 1980*

There are no information collection requirements in this regulation.

#### List of Subjects in 42 CFR Part 5

Shortage.  
Health.  
Health professionals.  
Psychiatrists.  
Psychologists.  
Social workers.  
Psychiatric nurse specialists.  
Marriage and family therapists.  
Primary medical care physicians.  
Dentists.

Dated: May 23, 1991.

James O. Mason,  
Assistant Secretary for Health.

Approved: October 10, 1991.

Louis W. Sullivan,  
Secretary.

Accordingly, 42 CFR part 5 is amended as set forth below:

#### **PART 5—DESIGNATION OF HEALTH PROFESSIONAL SHORTAGE AREAS**

1. The authority citation for 42 CFR part 5 continues to read as follows:

Authority: Sec. 215 of the Public Health Service Act, 58 Stat. 690 (42 U.S.C. 216); Sec. 332 of the Public Health Service Act, 90 Stat. 2770-2772 (42 U.S.C. 254e).

2. The heading for appendix C of part 5 is revised to read as follows:

#### **Appendix C—Criteria for Designation of Areas Having Shortages of Mental Health Professionals**

3. Part I.A of appendix C is revised to read as follows:

##### *Part I—Geographic Areas*

A. *Criteria.* A geographic area will be designated as having a shortage of mental health professionals if the following four criteria are met:

1. The area is a rational area for the delivery of mental health services.  
2. One of the following conditions prevails within the area:

(a) The area has  
(i) a population-to-core-mental-health-professional ratio greater than or equal to 6,000:1 and a population-to-psychiatrist ratio greater than or equal to 20,000:1, or

(ii) a population-to-core-professional ratio greater than or equal to 9,000:1, or  
(iii) a population-to-psychiatrist ratio greater than or equal to 30,000:1;

(b) The area has unusually high needs for mental health services, and has

(i) a population-to-core-mental-health-professional ratio greater than or equal to 4,500:1 and

a population-to-psychiatrist ratio greater than or equal to 15,000:1, or

(ii) a population-to-core-professional ratio greater than or equal to 6,000:1, or

(iii) a population-to-psychiatrist ratio greater than or equal to 20,000:1;

3. Mental health professionals in contiguous areas are overutilized, excessively distant or inaccessible to residents of the area under consideration.

\* \* \*

4. In Part I.B. Methodology, the term "psychiatric" in the heading of paragraph 1 and the text of paragraphs 1(a) and 1(a)(ii) is changed to "mental health". Paragraphs 3, 4, and 5 are revised to read as follows:

\* \* \*

3. *Counting of mental health professionals.* (a) All non-Federal core mental health professionals (as defined below) providing mental health patient care (direct or other, including consultation and supervision) in ambulatory or other short-term care settings to residents of the area will be counted. Data on each type of core professional should be presented separately, in terms of the number of full-time-equivalent (FTE) practitioners of each type represented.

(b) Definitions:

(i) *Core mental health professionals or core professionals* includes those psychiatrists, clinical psychologists, clinical social workers, psychiatric nurse specialists, and marriage and family therapists who meet the definitions below.

(ii) *Psychiatrist* means a doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who

(A) is certified as a psychiatrist or child psychiatrist by the American Medical Specialties Board of Psychiatry and Neurology or by the American Osteopathic Board of Neurology and Psychiatry, or, if not certified, is "broad-eligible" (i.e., has successfully completed an accredited program of graduate medical or osteopathic education in psychiatry or child psychiatry); and

(B) practices patient care psychiatry or child psychiatry, and is licensed to do so, if required by the State of practice.

(iii) *Clinical psychologist* means an individual (normally with a doctorate in

psychology) who is practicing as a clinical or counseling psychologist and is licensed or certified to do so by the State of practice; or, if licensure or certification is not required in the State of practice, an individual with a doctorate in psychology and two years of supervised clinical or counseling experience. (School psychologists are not included.)

(iv) *Clinical social worker* means an individual who

(A) is certified as a clinical social worker by the American Board of Examiners in Clinical Social Work, or is listed on the National Association of Social Workers' Clinical Register, or has a master's degree in social work and two years of supervised clinical experience; and

(B) is licensed to practice as a social worker, if required by the State of practice.

(v) *Psychiatric nurse specialist* means a registered nurse (R.N.) who

(A) is certified by the American Nurses Association as a psychiatric and mental health clinical nurse specialist, or has a master's degree in nursing with a specialization in psychiatric/mental health and two years of supervised clinical experience; and

(B) is licensed to practice as a psychiatric or mental health nurse specialist, if required by the State of practice.

(vi) *Marriage and family therapist* means an individual (normally with a master's or doctoral degree in marital and family therapy and at least two years of supervised clinical experience) who is practicing as a marital and family therapist and is licensed or certified to do so by the State of practice; or, if licensure or certification is not required by the State of practice, is eligible for clinical membership in the American Association for Marriage and Family Therapy.

(c) Practitioners who provide patient care to the population of an area only on a part-time basis (whether because they maintain another office elsewhere, spend some of their time providing services in a facility, are semi-retired, or operate a reduced practice for other reasons), will be counted on a partial basis through the use of full-time-equivalency calculations based on a 40-hour week. Every 4 hours (or ½ day) spent providing patient care services in ambulatory or inpatient settings will be counted as 0.1 FTE, and each practitioner providing patient care for 40 or more hours per week as 1.0 FTE. Hours spent on research, teaching, vocational or educational counseling, and social services unrelated to mental health will be excluded; if a practitioner

is located wholly or partially outside the service area, only those services actually provided within the area are to be counted.

(d) In some cases, practitioners located within an area may not be accessible to the general population of the area under consideration. Practitioners working in restricted facilities will be included on an FTE basis based on time spent outside the facility. Examples of restricted facilities include correctional institutions, youth detention facilities, residential treatment centers for emotionally disturbed or mentally retarded children, school systems, and inpatient units of State or county mental hospitals.

(e) In cases where there are mental health facilities or institutions providing both inpatient and outpatient services, only those FTEs providing mental health services in outpatient units or other short-term care units will be counted.

(f) Adjustments for the following factors will also be made in computing the number of FTE providers:

(i) Practitioners in residency programs will be counted as 0.5 FTE.

(ii) Graduates of foreign schools who are not citizens or lawful permanent residents of the United States will be excluded from counts.

(iii) Those graduates of foreign schools who are citizens or lawful permanent residents of the United States, and practice in certain settings, but do not have unrestricted licenses to practice, will be counted on a full-time-equivalency basis up to a maximum of 0.5 FTE.

(g) Practitioners suspended for a period of 18 months or more under provisions of the Medicare-Medicaid Anti-Fraud and Abuse Act will not be counted.

4. *Determination of unusually high needs for mental health services.* An area will be considered to have unusually high needs for mental health services if one of the following criteria is met:

(a) 20 percent of the population (or of all households) in the area have incomes below the poverty level.

(b) The youth ratio, defined as the ratio of the number of children under 18 to the number of adults of ages 18 to 64, exceeds 0.6.

(c) The elderly ratio, defined as the ratio of the number of persons aged 65 and over to the number of adults of ages 18 to 64, exceeds 0.25.

(d) A high prevalence of alcoholism in the population, as indicated by prevalence data showing the area's alcoholism rates to be in the worst quartile of the nation, region, or State.

(e) A high degree of substance abuse in the area, as indicated by prevalence data showing the area's substance abuse to be in the worst quartile of the nation, region, or State.

5. *Contiguous area considerations.* Mental health professionals in areas contiguous to an area being considered for designation will be considered excessively distant, overutilized or inaccessible to the population of the area under consideration if one of the following conditions prevails in each contiguous area:

(a) Core mental health professionals in the contiguous area are more than 40 minutes travel time from the closest population center of the area being considered for designation (measured in accordance with paragraph B.1(b) of this part).

(b) The population-to-core-mental-health-professional ratio in the contiguous area is in excess of 3,000:1 and the population-to-psychiatrist ratio there is in excess of 10,000:1, indicating that core mental health professionals in the contiguous areas are overutilized and cannot be expected to help alleviate the shortage situation in the area for which designation is being considered. (If data on core mental health professionals other than psychiatrists are not available for the contiguous area, a population-to-psychiatrist ratio there in excess of 20,000:1 may be used to demonstrate overutilization.)

(c) Mental health professionals in contiguous areas are inaccessible to the population of the requested area due to geographic, cultural, language or other barriers or because of residency restrictions of programs or facilities providing such professionals.

5. Part I.C is revised to read as follows:

C. *Determination of degree of shortage.* Designated areas will be assigned to degree-of-shortage groups according to the following table, depending on the ratio ( $R_c$ ) of population to number of FTE core-mental-health-service providers ( $FTE_c$ ); the ratio ( $R_p$ ) of population to number of FTE psychiatrists ( $FTE_p$ ); and the presence or absence of high needs:

#### High Needs Not Indicated

Group 1— $FTE_c=0$  and  $FTE_p=0$

Group 2— $R_c$  gte 6,000:1 and  $FTE_p=0$

Group 3— $R_c$  gte 6,000:1 and  $R_p$  gte 20,000

Group 4(a)—For psychiatrist placements only: All other areas with  $FTE_p=0$  or  $R_p$  gte 30,000

Group 4(b)—For other mental health practitioner placements: All other areas with  $R_c$  gte 9,000:1.

\* Note: "gte" means "greater than or equal to".

#### High Needs Indicated

Group 1— $FTE_c=0$  and  $FTE_p=0$

Group 2— $R_c$  gte 4,500:1 and  $FTE_p=0$

Group 3— $R_c$  gte 4,500:1 and  $R_p$  gte 15,000

Group 4(a)—For psychiatrist placements only: All other areas with  $FTE_p=0$  or  $R_p$  gte 20,000

Group 4(b)—For other mental health practitioner placements: All other areas with  $R_c$  gte 6,000:1.

6. A new paragraph D is added to part I, as follows:

D. *Determination of Size of Shortage.* Size of Shortage (in number of FTE professionals needed) will be computed using the following formulas:

(1) For areas without unusually high need:

Core professional shortage=area population/6,000—number of FTE core professionals

Psychiatrist shortage=area population/20,000—number of FTE psychiatrists

(2) For areas with unusually high need:

Core professional shortage=area population/4,500—number of FTE core professionals

Psychiatrist shortage=area population/15,000—number of FTE psychiatrists

7. Part II of appendix C is revised to read as follows:

#### Part II—Population Groups

A. *Criteria.* Population groups within particular rational mental health service areas will be designated as having a mental health professional shortage if the following criteria are met:

1. Access barriers prevent the population group from using those core mental health professionals which are present in the area; and

2. One of the following conditions prevails:

(a) the ratio of the number of persons in the population group to the number of FTE core mental health professionals serving the population group is greater than or equal to 4,500:1 and the ratio of the number of persons in the population group to the number of FTE psychiatrists serving the population group is greater than or equal to 15,000:1; or

(b) the ratio of the number of persons in the population group to the number of FTE core mental health professionals serving the population group is greater than or equal to 6,000:1; or,

(c) The ratio of the number of persons in the population group to the number of FTE psychiatrists serving the population group is greater than or equal to 20,000:1.

B. *Determination of degree of shortage.* Designated population groups will be assigned to the same degree-of-shortage groups defined in part I.C of this appendix for areas with unusually high needs for mental health services, using the computed ratio ( $R_c$ ) of the number of persons in the population group to the number of FTE core mental health service providers ( $FTE_c$ ) serving the population group, and the ratio ( $R_p$ ) of the number of persons in the population group to the number of FTE psychiatrists ( $FTE_p$ ) serving the population group.

C. *Determination of size of shortage.* Size of shortage will be computed as follows:

Core professional shortage=number of persons in population group/4,500—number of FTE core professionals

Psychiatrist shortage=number of persons in population group/15,000—number of FTE psychiatrists

8. Part III, section C, *Community Mental Health Facilities and Other Public or Nonprofit Private Facilities*, is amended by changing "psychiatric manpower" to "mental health professional(s)" and "psychiatric services" to "mental health services" wherever they occur in paragraphs 1, 2(a)(i) and 2(b), and in paragraphs 2(a)(ii) and 2(b) change "psychiatric services" to read "mental health services", by revising paragraphs 2(c) (i) and (ii) to read as follows, and by adding a new paragraph 2(c)(iii):

(c) *Insufficient capacity to meet mental health service needs.* A facility will be considered to have insufficient capacity to meet the mental health service needs of the area or population it serves if:

(i) there are more than 1,000 patient visits per year per FTE core mental health professional on staff of the facility, or

(ii) there are more than 3,000 patient visits per year per FTE psychiatrist on staff of the facility, or

(iii) no psychiatrists are on the staff and this facility is the only facility providing (or responsible for providing) mental health services to the designated area or population.

9. Appendix A, *Criteria for Designation of Areas Having Shortages of Primary Medical Care (Manpower,*

Part I—Geographic Areas, is amended by adding new paragraph D, as follows:

D. Determination of size of primary care physician shortage. Size of Shortage (in number of FTE primary care physicians needed) will be computed using the following formulas:

(1) For areas without unusually high need or insufficient capacity:

Primary care physician shortage = area population/3,500—number of FTE primary care physicians

(2) For areas with unusually high need or insufficient capacity:

Primary care physician shortage = area population/3,000—number of FTE primary care physicians

10. Appendix A, Part II—Population Groups, is amended by adding new paragraph C, as follows:

C. Determination of size of primary care physician shortage. Size of shortage (in number of primary care physicians needed) will be computed as follows:

Primary care physician shortage = number of persons in population group/3,000—number of FTE primary care physicians

11. Appendix B, Criteria for Designation of Areas Having Shortages of Dental Manpower, Part I—Geographic Areas, is amended by adding new paragraph D, as follows:

D. Determination of size of dental shortage. Size of Dental Shortage (in number of FTE dental practitioners needed) will be computed using the following formulas:

(1) For areas without unusually high need:

Dental shortage = area population/5,000—number of FTE dental practitioners

(2) For areas with unusually high need:

Dental shortage = area population/4,000—number of FTE dental practitioners

12. Appendix B, Part II—Population Groups, is amended by adding new paragraph C, as follows:

C. Determination of size of dental shortage. Size of dental shortage will be computed as follows:

Dental shortage = number of persons in population group/4,000—number of FTE dental practitioners

13. The entire text of part 5, including its title, is amended by replacing the word "manpower" throughout with the word "professional(s)".

[FR Doc. 92-1131 Filed 1-21-92; 8:45 am]

BILLING CODE 4160-15-M

## FEDERAL COMMUNICATIONS COMMISSION

### 47 CFR Part 73

[MM Docket Nos. 89-326, 89-327; RM-5138, RM-6315, RM-6448, RM-6765, RM-6779, RM-6782, RM-6836, RM-6840, RM-7304, RM-7305, RM-7306, RM-7307, RM-7308; FCC 92-4]

**Radio Broadcasting Services; Carolina Beach, Havelock, Hertford, Jacksonville, Fair Bluff, Wilmington, Shallotte and Longwood, North Carolina, and Murrells Inlet, Bucksport, Darlington, Loris, St. Stephen, North Myrtle Beach, Surfside Beach, Johnsonville, Scranton, Kure Beach, Georgetown and Stallville, South Carolina**

**AGENCY:** Federal Communications Commission.

**ACTION:** Final rule.

**SUMMARY:** The Commission resolves competing requests for FM channel allotments to various communities in North Carolina and South Carolina, pursuant to the Memorandum Opinion and Order consolidating consideration of MM Docket Nos. 89-326 and 89-327, as follows. See 55 FR 6643 (February 26, 1990) and Supplementary Information, *infra*. With this action, this proceeding is terminated.

**DATES:** Effective March 2, 1992. The window period for filing applications for Channel 294A at Carolina Beach, North Carolina, and Channel 300C2 at Bucksport, South Carolina, will open on March 3, 1992, and close on April 2, 1992.

**FOR FURTHER INFORMATION CONTACT:** Michael Ruger or Leslie K. Shapiro, Mass Media Bureau, (202) 634-6530.

**SUPPLEMENTARY INFORMATION:** This is a synopsis of the Commission's Report and Order, MM Docket Nos. 89-326 and 89-327, adopted January 2, 1992, and released January 15, 1992. The full text of this Commission decision is available for inspection and copying during normal business hours in the FCC Dockets Branch (room 230), 1919 M Street, NW., Washington, DC. The complete text of this decision may also be purchased from the Commission's copy contractor, Downtown Copy Center, (202) 452-1422, 1714 21st Street, NW., Washington, DC 20036.

The request of RJM Broadcasting to allot Channel 292A to either Stallville or Ladson, SC, is denied because Stallville is not a community for allotment purposes, and the Ladson proposal was untimely filed. The request of Great Southern Media to allot

Channel 235A to Longwood, NC, is dismissed because no timely filed expression of interest was received. At the request of Jones, Eastern of the Grand Strand, Inc., Channel 276C3 is substituted for Channel 276A at Surfside Beach, SC, and the license of Station WYAK(FM) is modified to specify operation on the higher powered channel. At the request of Marine Broadcasting Corporation, Channel 288C2 is substituted for Channel 288A at Jacksonville, NC, the license of Station WXQR-FM is modified to specify operation on the higher powered channel. Channel 283A is substituted for Channel 287A at Wilmington, NC, and the construction permit of Beatriz Garcia Suarez de McCommas is modified accordingly. At the request of G&M Communications, Channel 300C2 is allotted to Bucksport, SC, as that community's first local FM service. At the request of Musicradio of North Carolina, Inc., Channel 286C2 is substituted for Channel 285A at Havelock, NC, and the license of Station WMSQ(FM) is modified to specify operation on the higher powered channel. At the request of Maranatha Broadcasting Company, Inc., Channel 285C2 is substituted for Channel 285A at Hertford, NC, and the construction permit of Station WKJE(FM) is modified to specify the higher powered channel. At the request of Todd Spoeri, Channel 294A is allotted to Carolina Beach, NC, as the community's first local FM service. At the request of Jennings Communications Corporation, Channel 279C3 is substituted for Channel 228A at Shallotte, NC, the license of Station WDZD-FM is modified to specify operation on the higher powered channel, and Channel 252C3 is allotted to Shallotte for use by other interested parties. Spoeri's request to substitute Channel 252A for Channel 292A at Shallotte and modify the license of Station WCCA-FM accordingly, is denied because the allotment of Channel 252A would require the denial of two wide coverage area FM services at Shallotte. In addition, Spoeri failed to provide a sufficiently compelling showing demonstrating that Station WCCA-FM receives prohibited interference from Station WSYN-FM, Channel 293C2, Georgetown, SC. At the request of Ogden Broadcasting of South Carolina, Inc., Channel 290C3 is substituted for Channel 288A at North Myrtle Beach, SC, the license of Station WNMB(FM) is modified to specify the higher powered channel, Channel 291A is substituted for Channel 290A at St. Stephen, SC, the construction permit of Station WTUA-FM is modified to

specify the alternate Class A channel, and Channel 235A is substituted for Channel 290A at Loris, SC, and the construction permit of Robert L. Rabon is modified to specify operation on the alternate Class A channel. At the request of Radio Carolina Limited Partnership, Channel 288C3 is substituted for Channel 288A at Darlington, SC, and the license of Station WDAR-FM (formerly Station WMWG-FM) is modified to specify the higher powered channel. The request of RJM Broadcasting to allot Channel 289A to Georgetown, SC, as the community's fourth local FM service is denied because the upgraded operations at North Myrtle Beach and Darlington would provide additional service to more people than would a new station at Georgetown. In addition, the allotment of Channel 290C3 at North Myrtle Beach permits upgrades at Jacksonville, Havelock and Hertford. The request of Hendrix Broadcasting to allot Channel 294A to Kure Beach, SC, is dismissed because no expression of interest in use of the channel was received.

Coordinates for Channel 276C3 at Surfside Beach are 33-43-00 and 78-52-00, which reflect a site restriction of 15.8 kilometers (9.8 miles) northeast to avoid a short-spacing to the construction permit (BPH-880804MM) for a new station on Channel 275A at Scranton, SC. Because the petition which resulted in the allotment of Channel 276C3 at Surfside Beach was filed prior to October 2, 1989, Jones may avail itself of the provisions of Section 73.213(c)(1) with respect to the construction permit for Channel 275A at Scranton. Coordinates for Channel 288C2 at Jacksonville are 34-31-45 and 77-27-49, which reflects a site restriction of 24.5 kilometers (15.2 miles) south to avoid a short-spacing to the construction permit for Station WRSF-FM, Channel 289C, Columbia, NC, and the construction permit for Station WGQR-FM, Channel 289A, Elizabethtown, NC. Coordinates for Channel 283A at Wilmington, NC, are 34-16-15 and 77-57-23, the site specified in McCommas' outstanding construction permit. Because the petition which resulted in the allotment of Channel 283A to Wilmington was filed prior to October 2, 1989, McCommas may avail herself of the provisions of § 73.213(c)(1) with respect

to Station WCCG, Channel 283A, Hope Mill, NC. Coordinates for Channel 286C2 at Havelock are 34-49-42 and 76-42-12, which reflects a site restriction of 19 kilometers (11.8 miles) east to avoid a short-spacing to Station WDCG, Channel 286C, Durham, NC. Coordinates for Channel 285C2 at Hertford are 36-08-42 and 76-28-20, which reflects a site restriction of 5 kilometers (3.1 miles) south to avoid a short-spacing to Station WMXN, Channel 287B, Norfolk, VA. Coordinates for Channel 252C3 at Shallotte are 33-55-49 and 78-11-54, which reflects a site restriction of 17.6 kilometers (10.9 miles) east to avoid a short-spacing to the licensed site of Station WQSM, Channel 251C1, Fayetteville, NC. Coordinates for Channel 279C3 at Shallotte are 33-58-51 and 78-22-24, which reflects a site restriction of 1.3 kilometers (0.8 miles) northeast to avoid a short-spacing to Station WYAV, Channel 281C1, Conway, SC, and Station WZXS, Channel 280A, Topsail Beach, NC. Coordinates for Channel 294A at Carolina Beach are 33-58-30 and 77-54-50, which reflects a site restriction of 6.9 kilometers (4.3 miles) south to avoid a short-spacing to the licensed site of Station WSFL-FM, Channel 293C1, New Bern, NC. Because the petition which resulted in the allotment of Channel 294A to Carolina Beach was filed prior to October 2, 1989, applicants may avail themselves of the provisions of § 73.213(c)(1) of the Commission's Rules with respect to Station WSFL-FM, Channel 293C1, New Bern, NC. Coordinates for Channel 300C2 at Bucksport are 33-38-45 and 79-08-12, which reflects a site restriction of 3.2 kilometers (2.0 miles) southwest to avoid a short-spacing to the licensed site for Station WNCT-FM, Channel 300C, Greenville, NC. Coordinates for Channel 290C3 at North Myrtle Beach are 33-50-00 and 78-45-39, which reflects a site restriction of 7.2 kilometers (4.5 miles) west to avoid a short-spacing to Station WSYN-FM, Channel 293C2, Georgetown, SC. Coordinates for Channel 288C3 at Darlington are 34-20-40 and 80-01-02, which reflects a site restriction of 14.5 kilometers (9.0 miles) west to avoid a short-spacing to vacant but applied for Channel 287A, Fair Bluff, NC, and the applications for that channel. Because the petition which resulted in the allotment of Channel

288C3 at Darlington was filed prior to October 2, 1989, RCLP will be permitted to avail itself of the provisions of § 73.213(c)(1) of the Commission's Rules with respect to Station WJYQ, Channel 288A, Moncks Corner, SC, and to the allotment and pending applications for Channel 287A at Fair Bluff, NC. The coordinates for Channel 291A at St. Stephen are 33-29-36 and 79-53-21, the coordinates for Station WTUA-FM's construction permit. The coordinates for Channel 235A at Loris are 34-05-26 and 78-52-59, which reflect a site restriction of 2.5 kilometers (1.5 miles) north to avoid a short-spacing to the construction permit for Station WSSX-FM, Channel 236C, Charleston, SC.

#### List of Subjects in 47 CFR Part 73

Radio broadcasting.

#### PART 73—[AMENDED]

1. The authority citation for part 73 continues to read as follows:

Authority: 47 U.S.C. 154, 303.

#### § 73.202 [Amended]

2. Section 73.202(b), the Table of FM Allotments under North Carolina, is amended by adding Carolina Beach, Channel 294A; removing Channel 285A and adding Channel 286C2 at Havelock; removing Channel 285A and adding Channel 285C2 at Hertford; removing Channel 288A and adding Channel 288C2 at Jacksonville; removing Channel 228A and adding Channels 252C3 and 279C3 at Shallotte; and removing Channel 287A and adding Channel 283A at Wilmington.

#### § 73.202 [Amended]

3. Section 73.202(b), the Table of FM Allotments under South Carolina, is amended by adding Bucksport, Channel 300C2; removing Channel 288A and adding Channel 288C3 at Darlington; removing Channel 290A and adding Channel 235A at Loris; removing Channel 288A and adding Channel 290C3 at North Myrtle Beach; removing Channel 290A and adding Channel 291A at St. Stephen; and removing Channel 276A and adding Channel 276C3 at Surfside Beach.

Federal Communications Commission.

Donna R. Searcy,

Secretary.

[FR Doc. 92-1445 Filed 1-21-92; 8:45 am]

BILLING CODE 6712-01-M